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INTAKE QUESTIONNAIRE

Child's First Name:_____ Middle Initial:_____ Last Name_____

GOALS

My primary area (s) of concern at this time (check all that apply):
□ Sensory Processing □ Feeding □ Development □ Social/Emotional □ Functional Communication

Please describe, in your own words, what your current concerns for your child are at this time:_____

How can we be most helpful to you and your child?_____

What are your goals for your child:
In 1 month?_____
In 6 months?_____
In 1 year?_____
In 5 years?_____

MEDICAL HISTORY

Child's Primary Care Physician:
Name:_____ Profession:_____ Phone:_____
Address:_____
Date of Last Medical Checkup:_____ Height:_____ Weight:_____

Diagnosis: Please indicate any medical diagnosis or medical conditions below:

Medications: Please include prescription, homeopathic, over the counter and vitamin medications:

Allergies:

PREGNANCY HISTORY

Was the pregnancy for this child planned? □ Yes □ No
Did you have any problems getting pregnant? □ Yes □ No Comments:_____
In what month did you begin prenatal care?_____
Please list all medications taken during this pregnancy:_____

Did Mother have any of the following occur during this pregnancy?

YES	NO	Description	Explanation
		Allergy or Asthma	
		Anemia	
		Diabetes/blood sugar problems	
		Edema (swelling, water retention)	
		Excessive vomiting	
		Fatigue	

Did Mother have any of the following occurring during this pregnancy (cont.)			
YES	**NO**	**Description**	**Explanation**
☐	☐	Accidents	
☐	☐	Bleeding/spotting	
☐	☐	Blood pressure problems	
☐	☐	Blood transfusions	
☐	☐	Headaches/migraines	
☐	☐	Heart disease	
☐	☐	Infections (bladder or genital)	
☐	☐	Infections (other)	
☐	☐	Kidney disease	
☐	☐	Loss of a loved one	
☐	☐	Other physical injury	
☐	☐	Placed on bed rest	
☐	☐	Pre-eclampsia	
☐	☐	Pre-term labor	
☐	☐	Rh negative	
☐	☐	Severe stress	
☐	☐	Shock	
☐	☐	Toxemia	
☐	☐	Toxin exposure	
☐	☐	Use of drugs and/or alcohol	
☐	☐	Uterine or uterine fluid problems	
☐	☐	Other:	

BIRTH HISTORY

Hospital born:_____ City:_____ State:_____
Was your child born: ☐ On time ☐ Early_____ weeks ☐ Late_____ weeks
Length of labor:_____ hours Type of Delivery: ☐ Vaginal ☐ Cesarean Section (reason_____)
Presentation: ☐ Head ☐ Face ☐ Breech ☐ Transverse
Assistance: ☐ Forceps ☐ High Forceps ☐ Vacuum Suction ☐ Other_____
Was there a positive bonding between mother and newborn at birth? ☐ Yes ☐ No
What were the newborn's APGAR scores? 1 minute_____ 5 minute_____
Birth weight:_____ Birth Length:_____
Number of days spent in the nursery?_____ days NICU? ☐ Yes ☐ No _____ days
Did mother experience any post-partum depression? ☐ Yes ☐ No

Did any of the following problems occur **during the labor/delivery**?

YES	**NO**	**Description**	**Explanation**
☐	☐	Baby had cord wrapped around the neck	
☐	☐	Baby had heart rate decelerations	
☐	☐	Baby had very low or high heart rate	
☐	☐	Cord problems (knots, prolapsed, compression)	
☐	☐	Dysfunctional labor	
☐	☐	Fetal distress was noted	
☐	☐	Low or high blood cell count	
☐	☐	Maternal infection	
☐	☐	Meconium was noted	
☐	☐	Pelvis or cervical problems	
☐	☐	Placenta problems	
☐	☐	Other:	

Did any of the following problems occur for **newborn following birth**?

YES	**NO**	**Description**	**Explanation**
☐	☐	Anemia and/or transfusions	
☐	☐	Brain hemorrhage	
☐	☐	Cyanotic (was blue) at birth	
☐	☐	Had bruising	
☐	☐	Had tremors or seizures	
☐	☐	Jaundice (yellow)	
☐	☐	Required oxygen at birth	
☐	☐	Required resuscitation	
☐	☐	Required stimulation to breathe	
☐	☐	Rh incompatibility problems	
☐	☐	Very low muscle tone	
☐	☐	Was considered small for gestational age	

Did any of the following problems occur for **newborn following birth**?			
YES	**NO**	**Description**	**Explanation**
☐	☐	Aspiration (meconium or fluid)	
☐	☐	Choking or vomiting episodes	
☐	☐	Congenital birth defects	
☐	☐	Infections	
☐	☐	Needed medications	
☐	☐	Needed ventilation	
☐	☐	Respiratory distress signs or syndrome	
☐	☐	Tube feedings	

MEDICAL HISTORY OF CHILD

Does your child currently have or had a history of any of the following conditions, illness, or diagnoses?

YES	**NO**	**Description**	**Comments**
☐	☐	ADD/ADHD	
☐	☐	Allergies	
☐	☐	Anemia/blood disorder	
☐	☐	Anxiety disorder	
☐	☐	Asthma	
☐	☐	Autism Spectrum Disorder (ASD)	
☐	☐	Birth defect/genetic disorder	
☐	☐	Bone problem	
☐	☐	Cognitive delay	
☐	☐	Constipation problems	
☐	☐	Dehydration episodes	
☐	☐	Diarrhea problems	
☐	☐	Down's Syndrome	
☐	☐	Dyslexia	
☐	☐	Ear disorder	
☐	☐	Emotional disorder	
☐	☐	Eye infections	
☐	☐	Failure to thrive	
☐	☐	Feeding problems	
☐	☐	Fractured bones	
☐	☐	Fragile X Syndrome	
☐	☐	Frequent colds/respiratory illness	
☐	☐	Frequent ear infections	
☐	☐	Frequent strep throat/sore throat	
☐	☐	Head injuries or concussions	
☐	☐	Hearing loss	
☐	☐	Heart condition	
☐	☐	Hormonal problem	
☐	☐	Ingestion of toxins, poisons, foreign objects	
☐	☐	Joint problem	
☐	☐	Kidney/renal disorder	
☐	☐	Learning Disabilities (LD)	
☐	☐	Lung condition/respirator disorder	
☐	☐	Major childhood illnesses (e.g., croup, pox, measles, mumps, meningitis, etc.)	
☐	☐	Mood disorder	
☐	☐	Muscle disorder/muscle problem	
☐	☐	Neurological disorder	
☐	☐	PE tubes placed	
☐	☐	Seizures or convulsions	
☐	☐	Sensory Processing Disorder	
☐	☐	Significant accident/injury	
☐	☐	Skin disorder/skin problems	
☐	☐	Stomach disorder/stomach pain	
☐	☐	Tourette's Syndrome	
☐	☐	Urinary problems/infections	
☐	☐	Visual disorder/vision problems	
☐	☐	Vomiting/digestion problems	
☐	☐	Weight problems	
☐	☐	Other:	

Child Name:_____

Please list any hospitalizations your child has had and the reason. List the date(s) of any surgery you child has had and the reason:

FAMILY HISTORY

Marital Status of Parents: □ Married (Date:_____) □ Divorced (Date:_____) □ Separated (Date:_____) □ Other_____
What language(s) are spoken at home?_____

If both primary caregivers work, who cares for the child?
Name:_____ Relationship:_____ Avg time/day:_____

How would you describe your child's general adjustment at home? □ Poor □ Fair □ Good □ Excellent

How does your child get along with each member of the family?
Mother:_____
Father:_____
Siblings:_____

FAMILY STRESSORS (please note if any of the following stressful events happened in the **last 12 months**)

YES	NO	Event	Explanation
		Death in the family	
		Extended separation from parents	
		Financial crisis	
		Household move	
		Job change/difficulties	
		Legal problems	
		Marital separations/divorce	
		Medical problems	
		School problems	
		Other:	

Is there a family history of any of the following?

YES	NO	Event	Relationship to Child	Comments
		Left hand preference or ambidexterity		
		Learning difficulties		
		Behavioral challenges		
		Neurological concerns		
		Mental health concerns		
		Drug or alcohol abuse		
		Other:		

DEVELOPMENTAL HISTORY

What are your child's gifts/strengths?_____

What do you enjoy most about your child and family?_____

What kind of interests and activities does your child have? (i.e., hobbies, sports, clubs, favorite toys/games?)_____

Describe your child in the first two years of life. (i.e., feeding, sleeping, activity level, etc.)_____

Describe your child in toddler stage_____

DEVELOPMENTAL MILESTONES:
Please indicate the age when your child first did each of the following INDEPENDENTLY.

Milestone	N/A	Early	On Time	Late	Age Achieved	Comments
Smiled						
Held head up						
Rolled over						
Reached for an object						
Transferred object between hands						

Please indicate the age when your child first did each of the following INDEPENDENTLY.						
Milestone	**N/A**	**Early**	**On Time**	**Late**	**Age Achieved**	**Comments**
Sat unsupported						
Crawled						
Stood alone						
Walked by self						
Said first words						
Threw objects actively						
Ran by self						
Followed simple 1 step directions						
Said 2-3 word phrases						
Ate unaided with a spoon						
Dressed self						
Chewed solid food						
Drank from an open cup						
Rode bicycle without training wheels						
Caught a thrown object (ball)						
Demonstrated hand preference (which?)						
Knew colors						
Counted to 5						
Knew alphabet						
Bladder trained: days						
Bladder trained: nights						
Bowel trained						

Describe your tummy time experience with your child (i.e., tolerance, length of time, etc.)_____

Describe your child's position with crawling (i.e., hands and knees), army crawl, scooted on bottom, etc.)_____

AUDITORY:
Does your child have any problems with hearing? □ Yes □ No Comments:_____

When was the last time your child had their hearing tested?_____

COMMUNICATION:
Does your child have any problems with communication? □ Yes □ No Comments:_____

FEEDING:
Does your child have any problems with feeding? □ Yes □ No Comments:_____

MOTOR:
Does your child have any problems with gross motor movements? □ Yes □ No Comments:_____

Does your child have any problems with fine motor movements? □ Yes □ No Comments:_____

SELF CARE:
Does your child have any problems with self-care tasks (i.e., dressing, bathing, eating, following daily routines)? □ Yes □ No
Comments:_____

SENSORY:
Does your child seem to be overly sensitive to sensory experiences more than others (over-reacts)? □ Yes □ No
Comments:_____

Does your child seem to be under sensitive to sensory input more than others (under-responsive or seeks out input)? □ Yes □ No
Comments:_____

Does your child seem to have difficulty learning new movements or tasks? □ Yes □ No
Does your child seem less coordinated than others? □ Yes □ No

VISION:
Does your child have any problems with eyesight or vision? □ Yes □ No □ Comments:_____

When was the last time your child had their vision tested?_____

ACADEMIC HISTORY

Describe your child's experience learning from preschool to present time_____

_____

_____

Name of Current School:_____ Grade:_____

Address:_____

Phone:_____ Teacher:_____

Describe any concerns shared by the teacher:_____

_____

Does your child have an IEP in place? □ No □ Yes If Yes, which of the following apply: □ OT □ PT □ SLP □ Education Support

BEHAVIORAL HISTORY

Do any of the following behaviors describe your child now or in the past?

YES	NO	Description	Explanation/Comments
		Able to self soothe when upset	
		Aggression	
		Any unusual fears	
		Bedwetting	
		Breath holding	
		Calmed by car rides or infant swings	
		Colic or "fussy" baby	
		Destructiveness	
		Disliked lying on back	
		Disliked lying on stomach	
		Enjoy bouncing	
		Excessive drooling	
		Extended separations in first 2 years	
		Fire play or cruelty to animals	
		Frequent Temper tantrums	
		Head banging	
		Major mood swings	
		Masturbation	
		Nauseated by car rides or infant swings	
		Nervous habits (i.e. nail biting)	
		Nightmares or night terrors	
		Preferred certain positions as an infant	
		Sleeping problems	
		Thumb sucking	
		Toe walker	
		Tolerate a regular schedule	
		Other:	

Describe a typical day for your child:_____

_____

_____

_____

PREVIOUS TESTING and TREATMENT

Has your child ever been assessed, examined, evaluated, or treated in any of the following areas?

	YES	NO	Start Date	End Date	Provider	Location
Academic						
Audiology						
Feeding						
Medical						
Psychological						
Occupational Therapy						
Physical Therapy						
Speech Therapy						
Other:						

Child Name:_____